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Understanding the Myths and Facts of Access to Primary Care for People with Mental Illness

April 17, 2017

SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

Moderators:

Mindy Klowden, Director of Technical Assistance, CIHS

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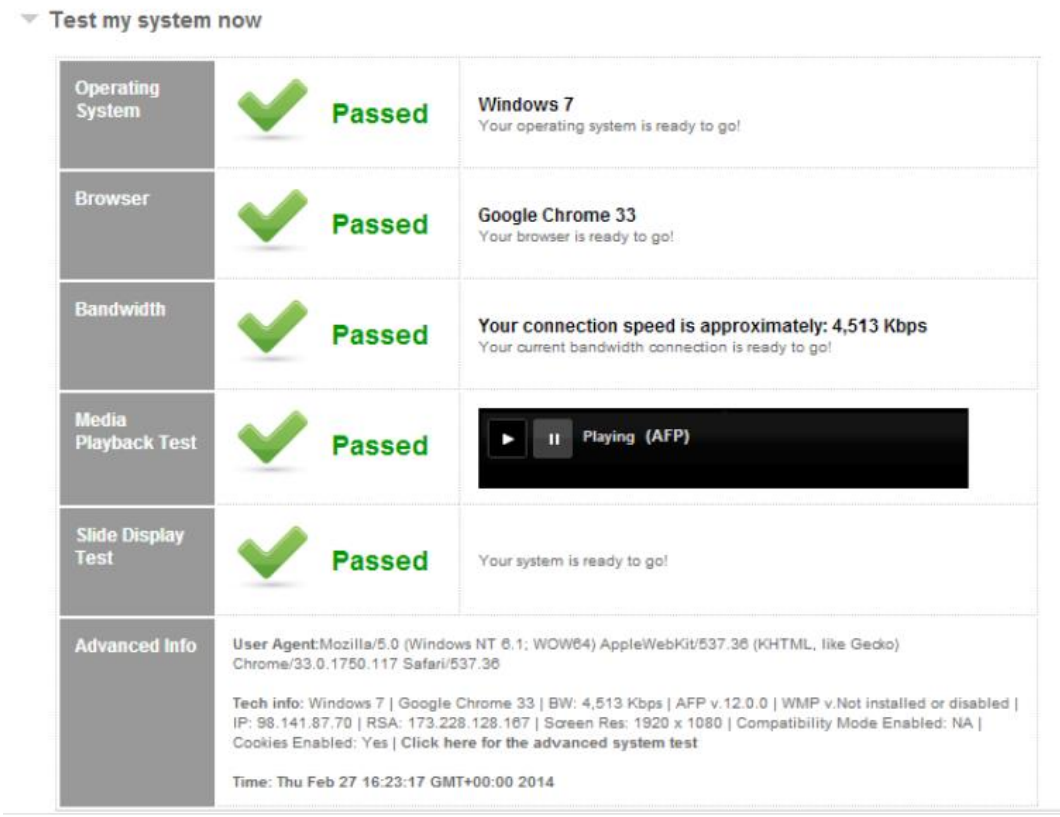

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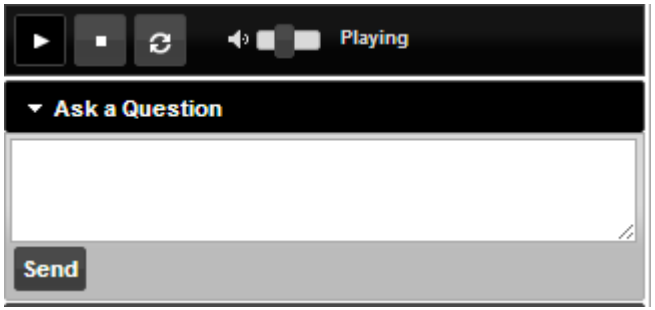

Learning Objectives

- Understand the leading reasons why individuals with serious mental illness may not access primary care
- Gain strategies for how to engage people with mental illness in primary care and wellness services
- Identify resources that offer additional information on integrating primary care and wellness services

Poll Question 1

Do you routinely ask your clients/patients if they have seen a primary care provider in the last year?

- Yes
- No
- I don’t know

Poll Question 2

Do you routinely ask your clients/patients about barriers to accessing primary care they may be experiencing, and employ strategies such as care coordination services, use of peer health staff, etc. to help mitigate those barriers?

- Yes
- No
- No, but I want to start doing so
- I don’t know

Poll Question 3

Do you utilize the Patient Activation Measure (PAM) or other evidence based tool to gauge level of patient activation and self-efficacy?

- Yes
- No

Today's Speakers

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Disclaimer: The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), or the U.S. Department of Health and Human Services (HHS).

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Primary Health Care Needs of Latinos with Serious Mental Illness: From Barriers to Solutions

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- **Collaborators:** Quisqueya Meyreles, Lucia Capitelli, Juana Alvarez, Richard Younge, Diana Dragatsi, Arminda Gomes, Benjamin Druss, Roberto Lewis-Fernández, Ana Stefancic, and Talhah Avi

- **Community Partners:** Washington Heights Community Service: Inwood Clinic

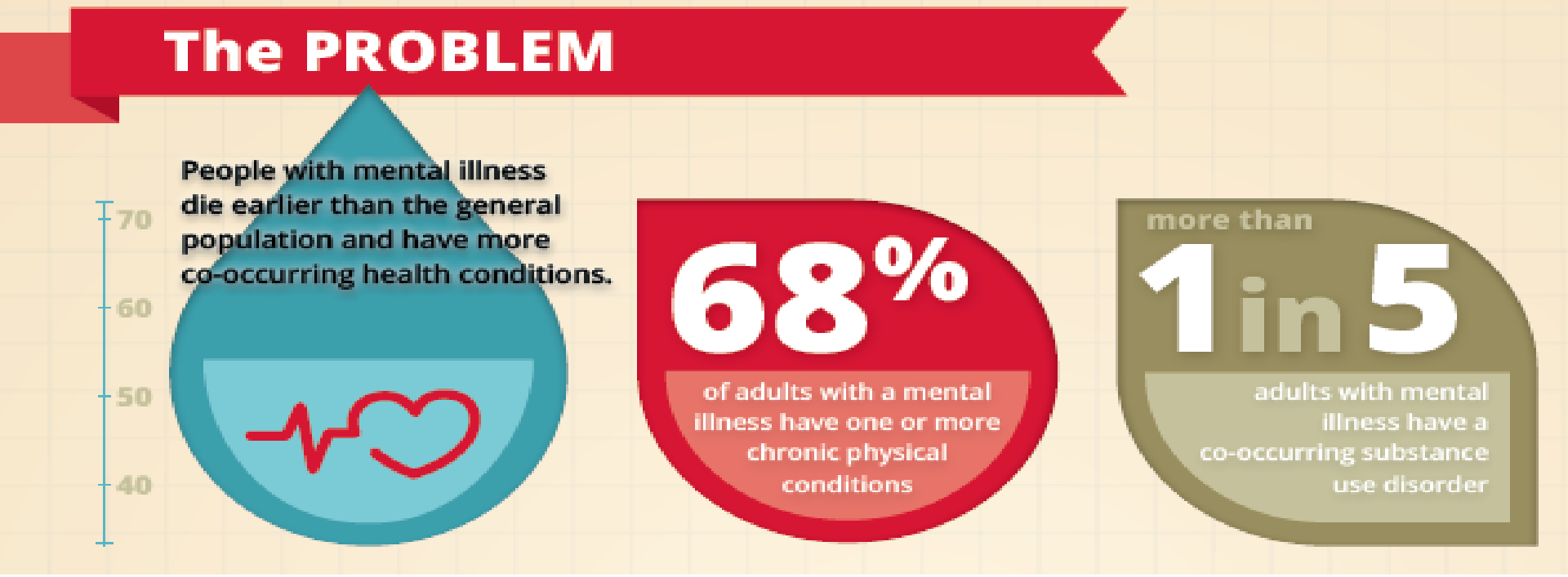
- **Doctoral Students**: David Camacho, and Carolina Velez-Grau

- **MSW Students**: Lorena Maldonado, Seth Thompson, Analis Lopez, Marina Soto, and Shirley Capa,

Objectives

- Discuss physical health disparities among Latinos with serious mental illness (SMI)
- Present factors that influence the primary health care experiences of Latinos with SMI
- Present Bridges to Better Health and Wellness, a culturally-adapted health care manager intervention for Latinos with SMI

The PROBLEM



Compared to the general population, people with SMI have shorter life expectancies (**20 years shorter for men; 15 years shorter for women**) largely due cardiovascular disease

Sources: Laursen et al., 2014; SAMHSA-HRSA Center for Integrated Health Solutions; Walker et al., 2015

Is There a Double Health Burden for Latinos with SMI?

Available online at www.sciencedirect.com
ScienceDirect
Comprehensive Psychiatry 55 (2014) 233–247
COMPREHENSIVE PSYCHIATRY
www.elsevier.com/locate/comppsych

Prevalence of cardiovascular risk factors among racial and ethnic minorities with schizophrenia spectrum and bipolar disorders: a critical literature review

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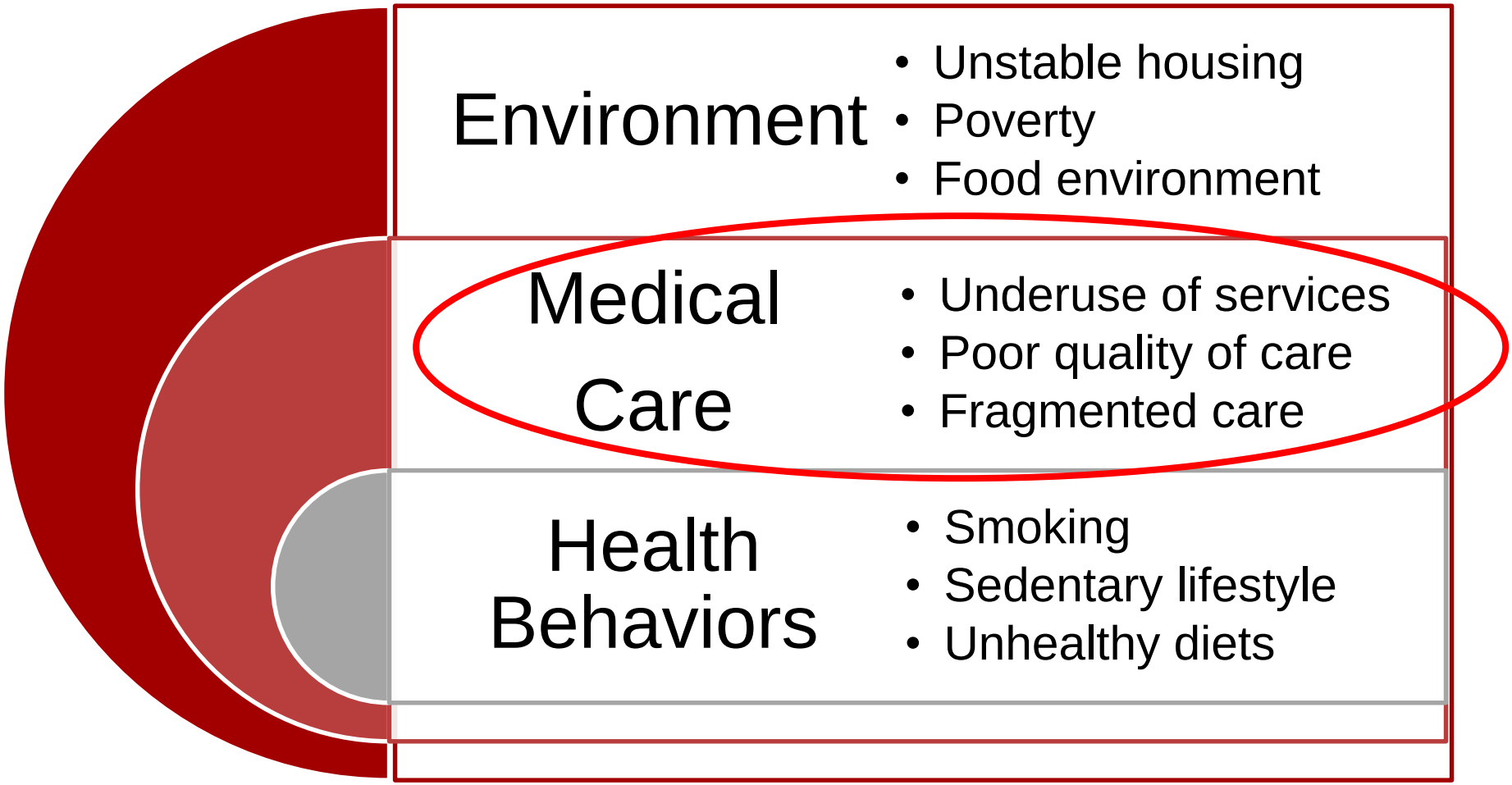
- Some evidence indicating increased risk for:
  - Cardiovascular-related mortality
  - Diabetes mellitus
  - Metabolic syndrome
  - Negative metabolic abnormalities (e.g., weight gain) associated with taking second- generation antipsychotic medications
- Evidence is inconclusive
  - Small samples sizes (n = 4-260)
  - Mostly clinical samples
  - Few analyses stratified by Latino sub-group and gender

Source: Carliner et al. *Com. Psych*, 2014, 55: 233-247

Modifiable Risk Factors



Sources: Allison et al., 2009; Cabassa et al., 2014; Newcomer et al., 2007

Primary Health Care Experiences of Latinos with SMI

Stressed Health Care System

Fragmented care

Long waiting times

Language barriers

High staff turnover

Perceived Discrimination and Stigma

Source: Cabassa et al., *Adm Policy Ment Health*. 2014:41:724-736

Perceived Discrimination and Stigma in the Health Care System (N = 40)

- 75% reported that racism is a problem in the health care system.

- People are treated unjustly in the health care system because:
  - They are Latino/a: 60%
  - They do not speak English very well: 68%
  - They have a serious mental illness: 65%
  - They are immigrants: 83%
  - They are Black: 65%

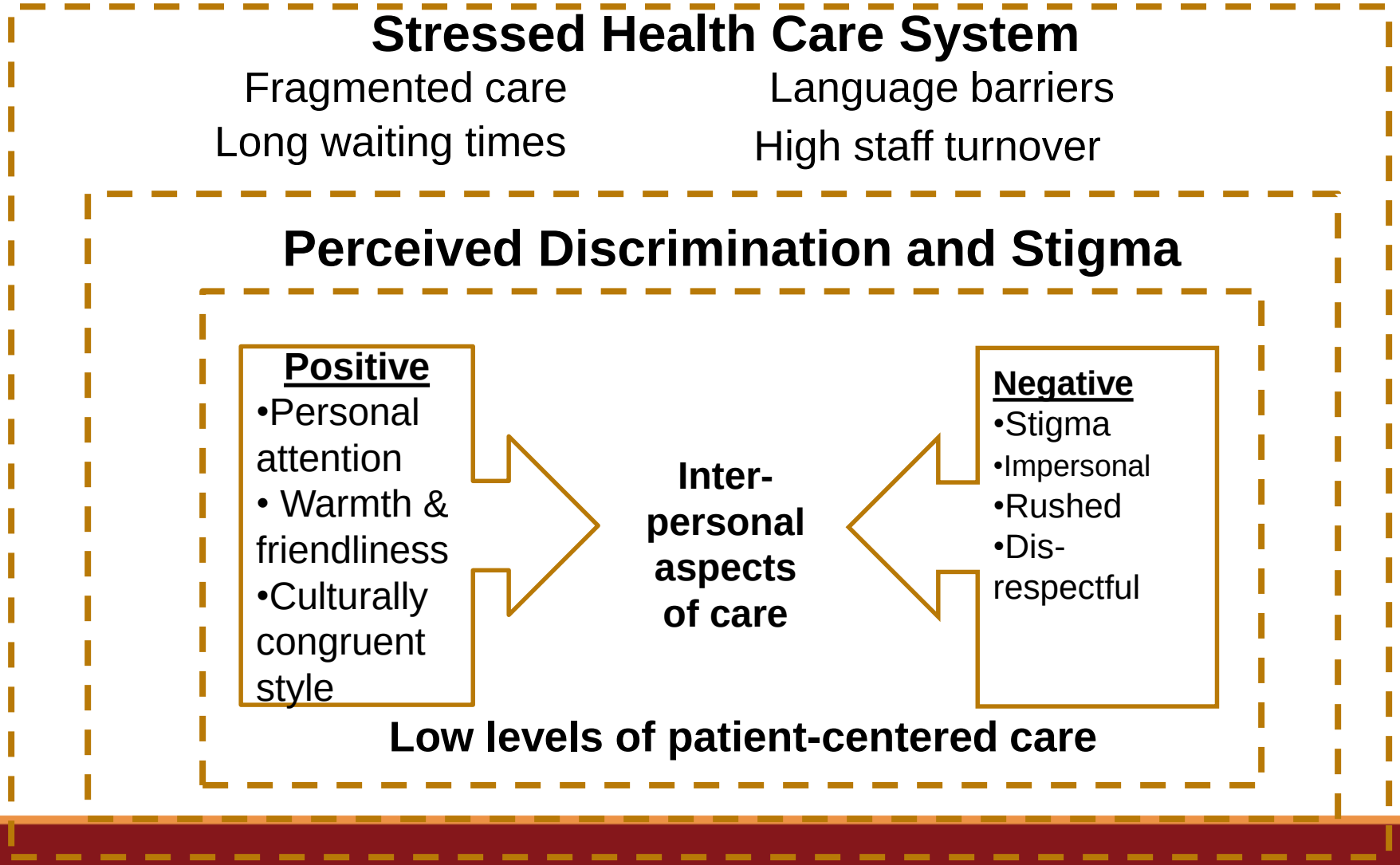
Source: Cabassa et al., *Adm Policy Ment Health*. 2014:41:724-736

Example of Stigma Experience

"One time it happened in the hospital. My stomach hurt and I kept telling them, but they just gave me a Tylenol. I ended up passing out. It was my appendix . . . They just did not believe me" (Latina female participant with schizophrenia).

Source: Cabassa et al., *Adm Policy Ment Health*. 2014:41:724-736

Primary Health Care Experiences of Latinos with SMI



Health Care Manager Interventions Can Address Many of These Barriers to Care

Care coordination/
System navigation → Reduce fragmented care and language barriers

Goal setting
Patient activation
Problem solving → Cope with perceived discrimination/stigma, improve patient-provider interactions, and increase patient-centered care

Sources: Bartels et al., 2004; Druss et al., 2010; Kilbourne et al., 2008

Local Implementation Gap

- Use of health care manager interventions with Latina/os with SMI is unknown
- The influence of culture on the health care of people with SMI is often ignored
- Can social workers be health care managers?

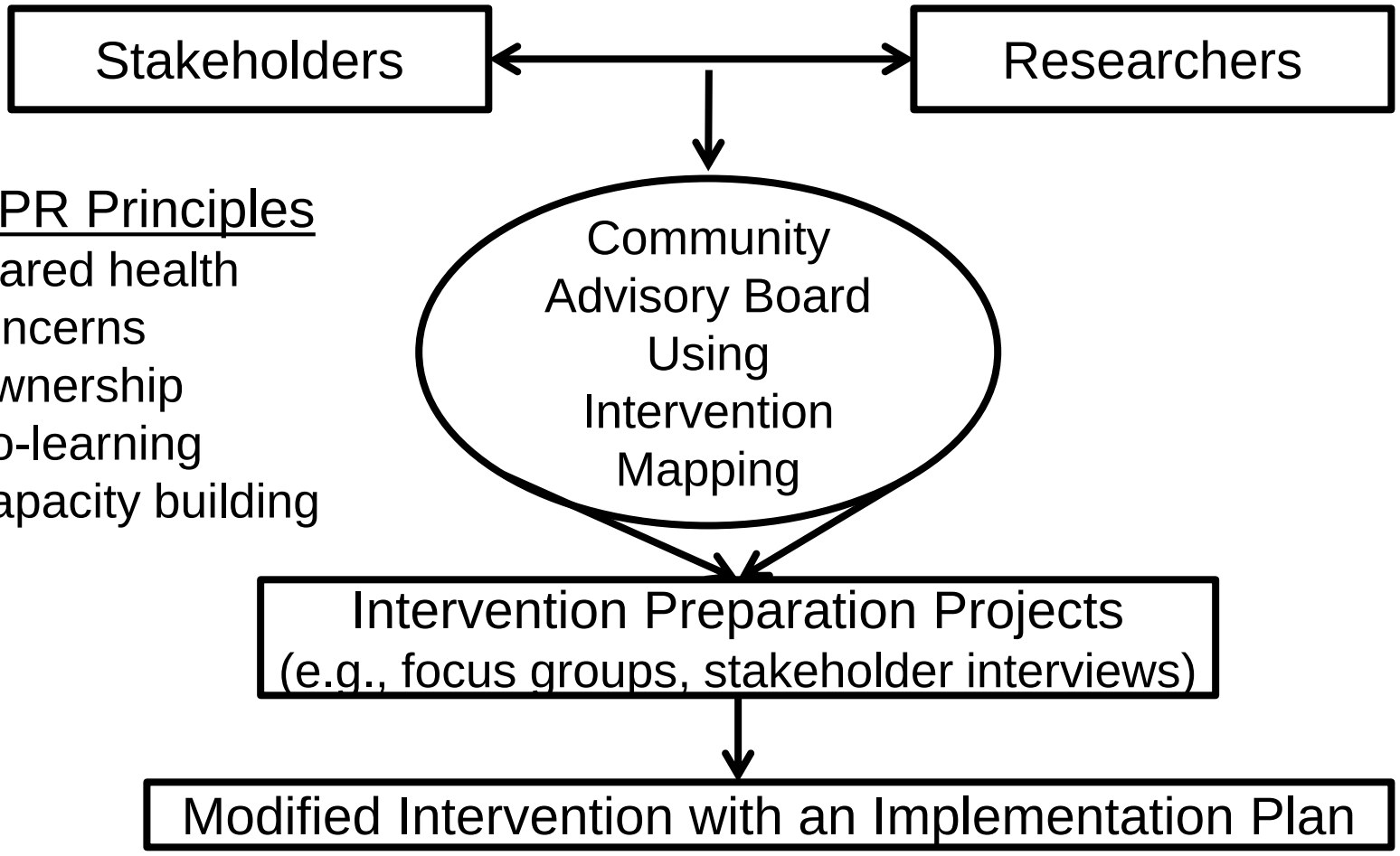
Few systematic and collaborative intervention planning models exist to inform adaptations of health care manager interventions to local settings

Source: Cabassa et al. *Implement Sci.* 2011: 6:80

Local Context

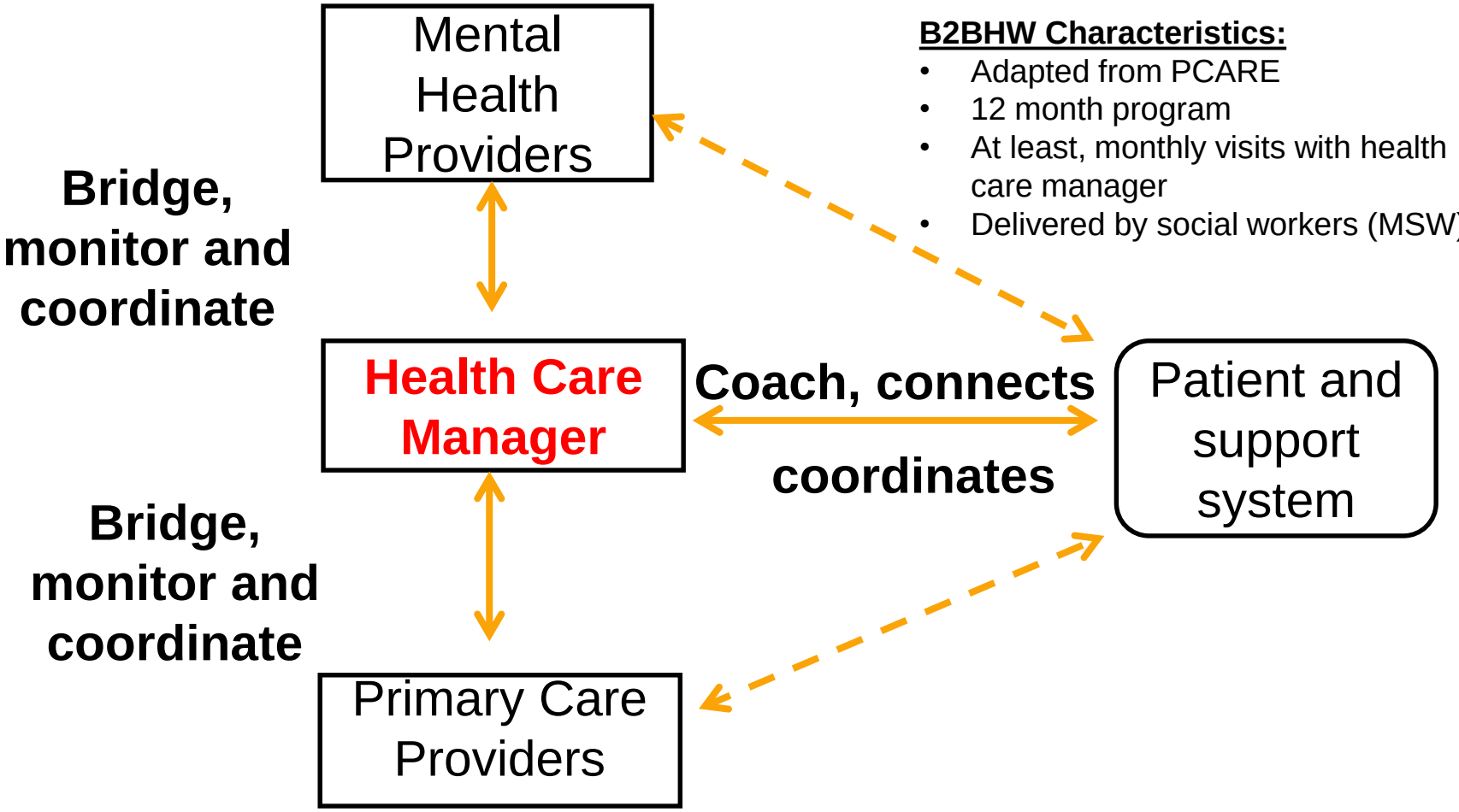
- Public outpatient mental health clinic in Upper Manhattan
- Serves Latina/o adults with serious mental illness
- Staffing
  - Social workers
  - Psychiatrists
  - Peer Specialist
  - Psychiatric nurses
- Patients referred to local primary care clinics for primary care services

Collaborative Intervention Planning Framework



Source: Cabassa et al. *Implement Sci.*, 2014. 9:178.

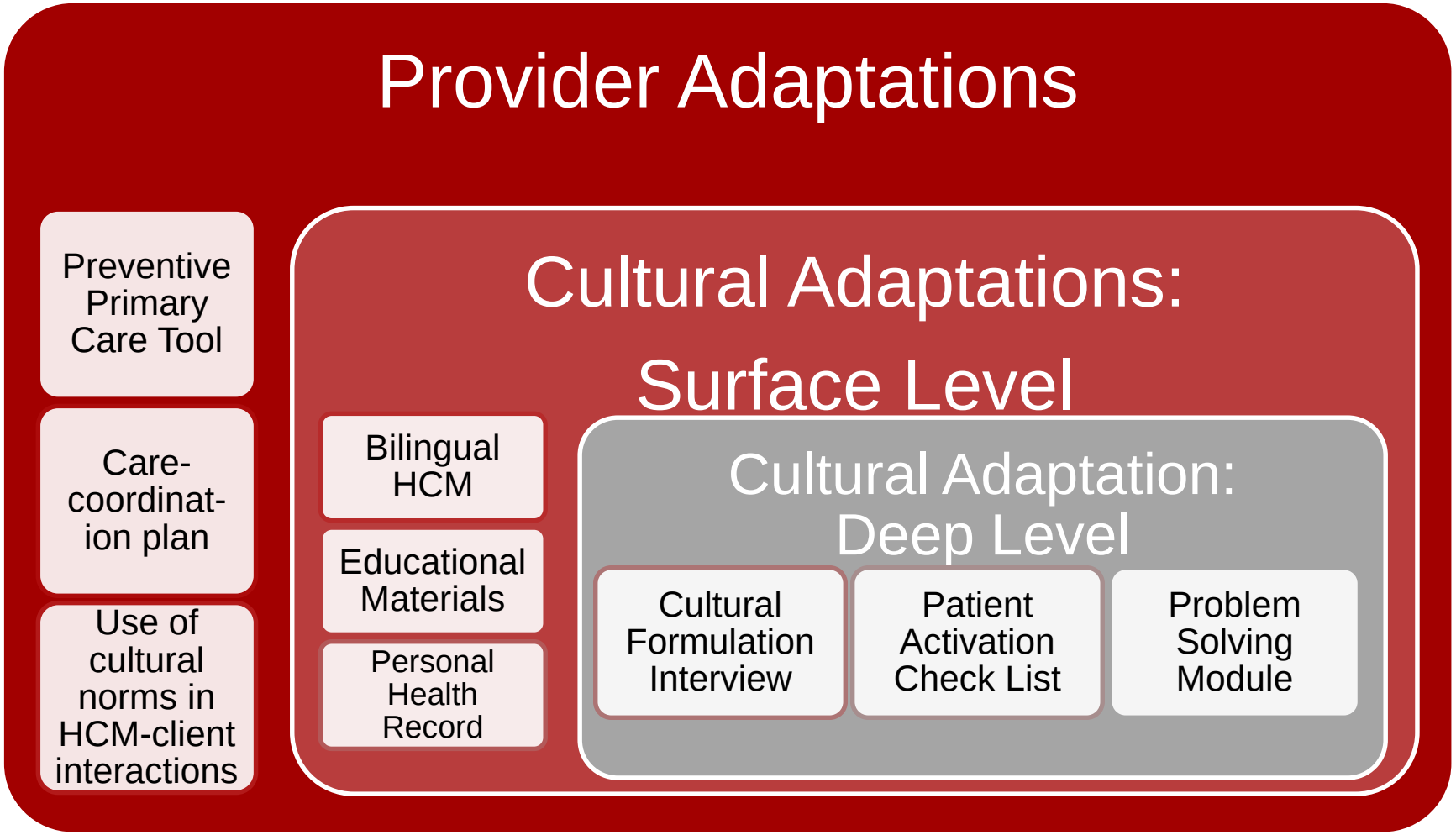
Bridges to Better Health and Wellness (B2BHW)



B2BHW Characteristics:

- Adapted from PCARE
- 12 month program
- At least, monthly visits with health care manager
- Delivered by social workers (MSW)

Provider and Cultural Adaptations



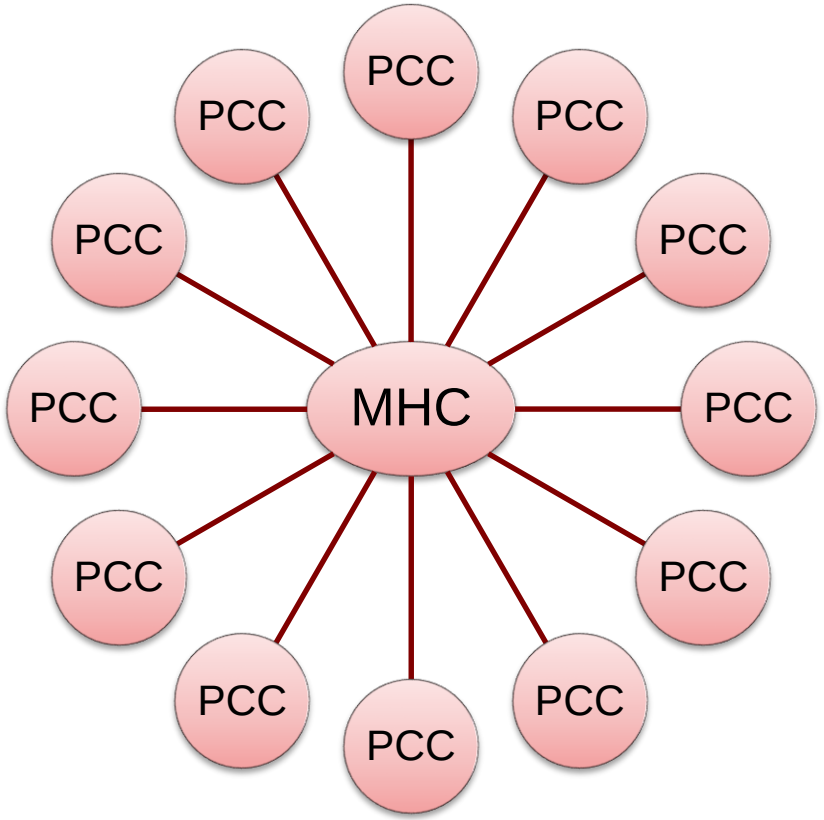
Source: Cabassa et al. *Implement Sci.*, 2014. 9:178.

Provider Adaptation: Care Coordination

Original PCARE Trial

Mental Health Clinic (MHC) ↔ Primary Care Clinic (PCC)

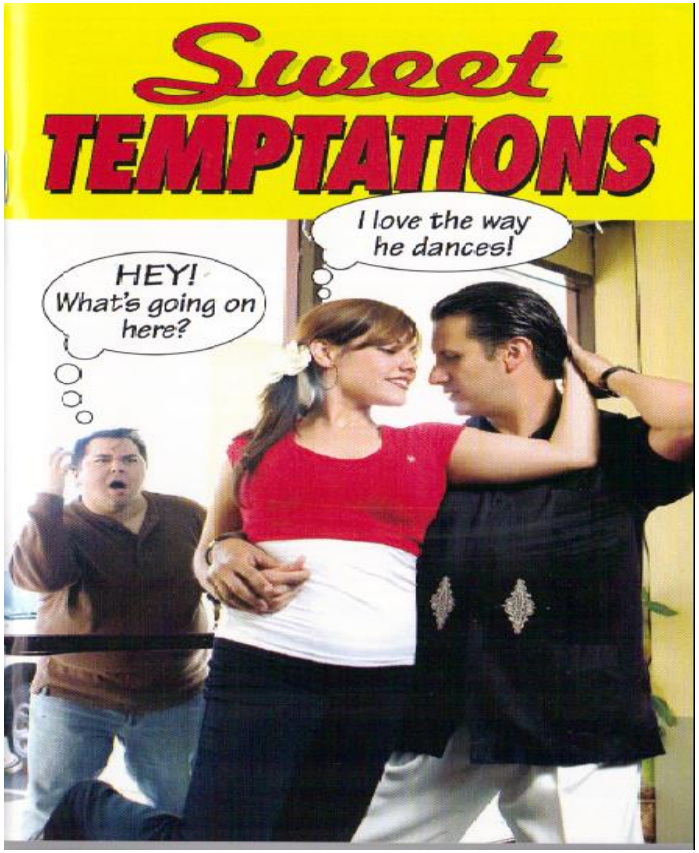
B2BHW Study



Source: Cabassa et al. *Implement Sci.*, 2014. 9:178.

Cultural Adaptations (Surface Level): Health-Related *Fotonovelas*

- Soap opera narrative to engage readers
- Relatable language, characters, and visuals
- Education-entertainment approach to increase knowledge and model appropriate health behaviors



BRIDGES TO BETTER HEALTH AND WELLNESS (B2BHW) PILOT

Source: Cabassa et al., *Admin. & Pol. in Mental Health Services,* In Press

Methods

- **Setting**: Public outpatient mental health clinic serving predominantly Latina/o adults with SMI in New York City
- **Design:**
  - 12 month pre-post one-group design
  - Structured interviews and medical chart abstractions at baseline, 6, and 12 months
  - 3 post-intervention focus group
- **Sample:** N = 34 Latina/os with SMI and at risk for cardiovascular disease
- **Fidelity:** Intervention manual, review and fidelity coding of audio recorded health care manager sessions, and monthly supervision meetings
- **Analysis:** Content analysis of focus group data and linear mixed model adjusting for health care manager assignment

Measures

- **Feasibility**: Recruitment, assessment completion, and treatment attendance
- **Acceptability:** Client satisfaction questionnaire and focus group data
- **Intervention Outcomes:**
  - Patient activation
  - Self-efficacy
  - Perceptions of chronic illness care quality
  - Receipt of preventive primary care (Chart abstraction for the receipt of US Preventive Task Force Guidelines)
  - Physical and mental health-related quality of life

RESULTS

Sample Characteristics (N = 34)

- Female = 67.6%
- Mean age = 54 (sd = 11.5),
- Mean years of education = 10.4(sd = 3.9)

Place of Birth:
- US: 11.8%
- Dominican Republic: 73.5%
- Puerto Rico: 2.9%
- Other: 11.8%

Language:
- Monolingual Spanish: 73.5%
- Bilingual: 26.5%

- Perceived health (Poor/Fair) = 64.7%
- Physical Health Chart Diagnoses:
  - Obese: 62.5%
  - High cholesterol: 75%
  - Diabetes: 47%
  - Hypertension: 62%
  - Arthritis: 21.9%

- Mean # of chronic medical conditions: 2.81 (sd = 1.62)
- Used Primary Care Services in the past 12 months: 97%
- Average number of visit past 12 months
  - Primary Care: 3.65 (sd = 2.52)
  - ER: 0.56 (sd = 1.07)

Mental Health Characteristics (N = 34)

Mental Health Chart Diagnosis

- Schizophrenia = 6.3%
- Schizoaffective Disorder = 40.6%
- Major Depression = 25%
- Bipolar Disorder = 25%
- Major Depression with Psychotic Features = 18.8%

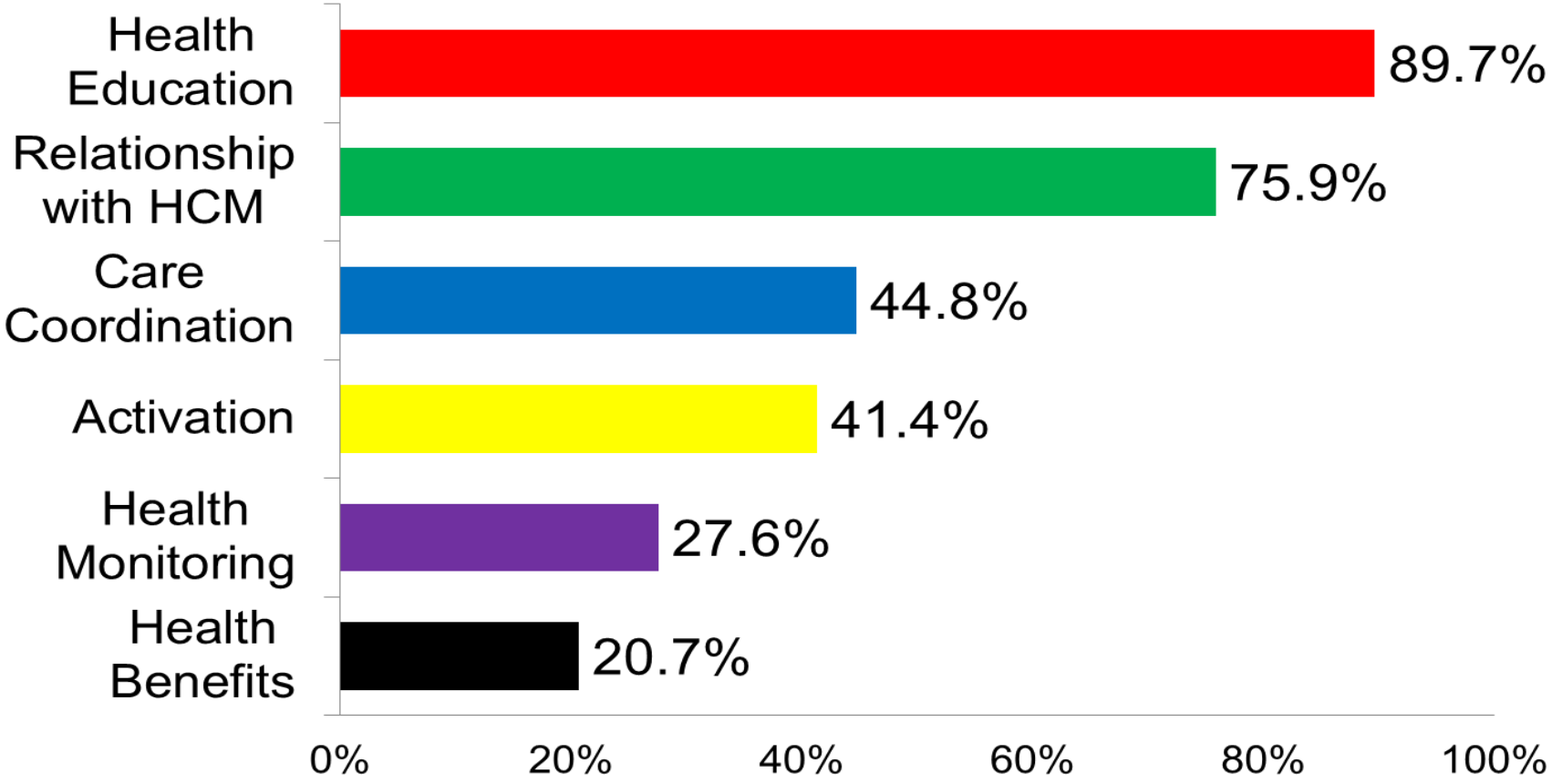
Mean # of hospitalizations for MH in past 12 months: 0.59 (1.28), range (0-7)

Mean # of ER visits for mental disorders in the past 12 Months: 0.65 (1.30), range (0-7)

Acceptability of B2BHW (N = 29)

- 85% of participants completed the intervention
- 93% rated the quality of services as good/excellent
- 86% indicated B2BHW met most/all of their health needs
- 97% were mostly/very satisfied with the amount of help they received from B2BHW
- 100% reported that:
  - B2BHW helped them deal more effectively with their physical health
  - Would recommend B2BHW to a friend

What Participants Liked Most about B2BHW (N = 29)

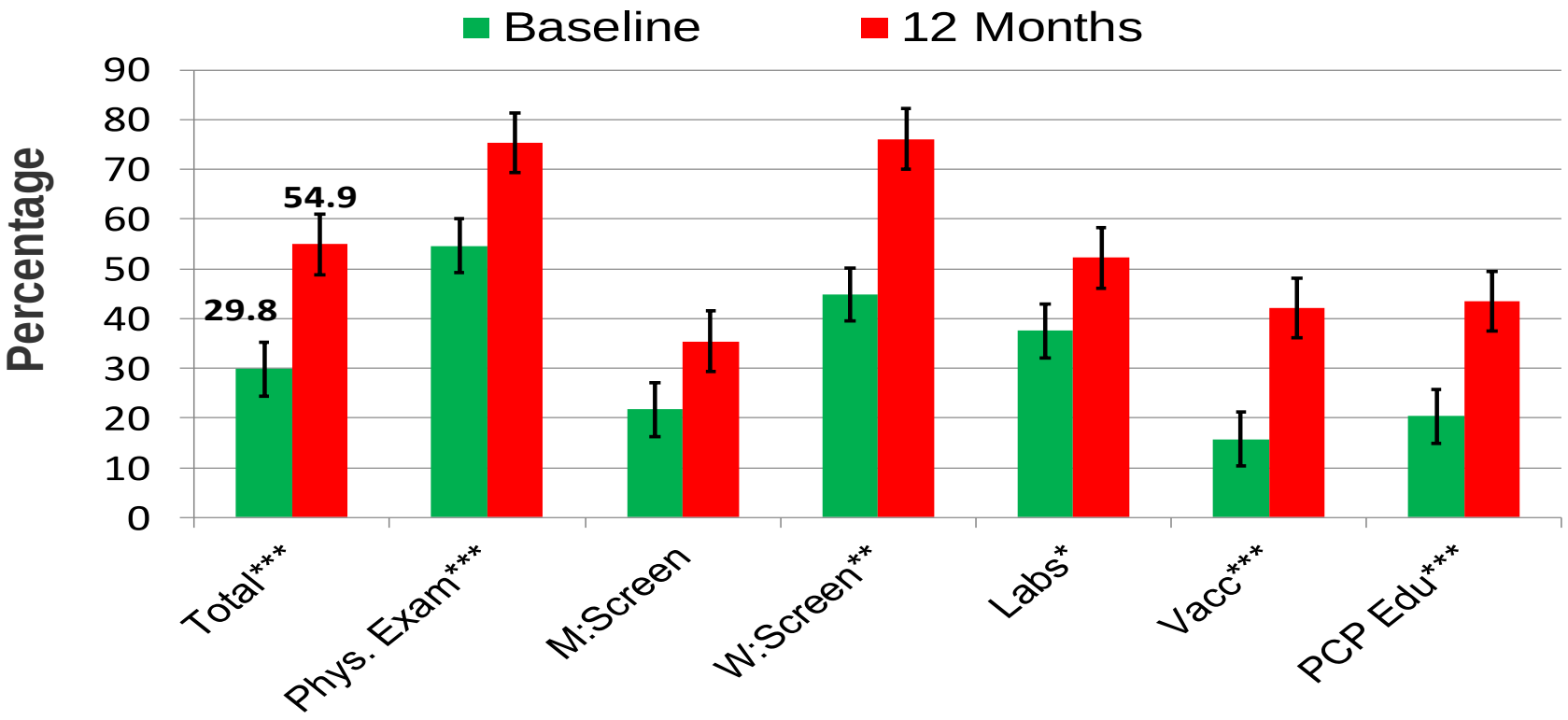


Patient-Centered and Health Outcomes

- Significant improvements in patient-centered outcomes from baseline to 12 months:
  - **Patient Activation**: 56.8 to 72.03, $p < 0.01$, ES = 0.56
  - **Self-Efficacy**:
    - Talking with doctor: 7.62 to 8.89, $p < 0.01$, ES = 0.49
    - Managing chronic illness: 5.57 to 6.88, $p < 0.01$, ES = 0.55
  - **Patients' Assessment of Chronic Illness Care**: **Health Care Manager:** Total: 2.81 to 4.08, $p < 0.01$, ES = 0.63

- No significant improvements in health- related quality of life (SF-12) and health outcomes (e.g., weight, blood pressure) were found

Receipt of Preventive Primary Care Services



Note: Adjusted for HCM assignment * p ≤ 0.05, ** p ≤ 0.01, ***p ≤ 0.001

Discussion

- Latina/os with SMI face a constellation of barriers accessing and using primary care
- Culturally-adapted health care manager programs like B2BHW can help reduce these barriers.
- B2BHW was feasible to deliver by social workers
  - 85% of participants completed the intervention
- Over the course of 12-months, we saw significant improvements in:
  - Patient activation
  - Self-efficacy
  - Patients' assessment of the chronic illness care
  - Receipt of preventive primary care services

Source: Cabassa et al., Admin. & Pol. in Mental Health Services, In Press

Limitations

- Small sample
- One site
- Single-group design

Conclusions

- Culturally-adapted health care manager interventions can help address the barriers Latina/os with SMI face accessing and using primary care services
- B2BHW shows promise for improving patient-centered care outcomes and preventive primary care services
- Future work is needed to test B2BHW effectiveness and potential for implementation

Thank You // Gracias

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Peer Personal Story

Robert (Bob) Fortano

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Barriers and Facilitators to Receiving Healthcare Services

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Yale School of Medicine, Department of Psychiatry Program for Recovery and Community Health

PCORI Wellness Enhancement Project (Project WE) (PI: Chyrell Bellamy)

Acknowledgements: PCORI Grant title: Increasing Health Care Choices and Improving Health Outcomes Among Persons with Serious Mental Illness.

Introducing the WE Team:

WE TEAM	WE Advisory Team/ Partners
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Kimberly Guy, Engagement Specialists	Robert Fortano
Luz Ocasio, Research Assistant	Richard Baxter
Lorraine Johnson, Research Assistant	Doris Doward
Yolanda Herring, Co-Researcher	Richard Youin
Merarilisse Crespo, Research Assistant	
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Jeanne Steiner, Co-Investigator	
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Rosalyn Forant, Co-Researcher	Robert Cole
Anthony Pavlo, Post Doc	Ed Renaud
Michelle Piczko, Co-Researcher	
Margaret Swarbrick, Consultant	
Chyrell D Bellamy, PI	

Introduction

Systemic barrier to access to health care

- **Lack of integration between primary and mental health care**

AND

- **Separation of mental health services from other medical services**

Introduction

Facilitators to access to health care

- **Social support – especially from family**
- **Continuity of care (seeing same healthcare provider)**
- **Reasonable income**
- **Teamwork support (positive working environment)**
- **Effective leadership and decision making**

Introduction

The Connecticut Mental Health Center (CMHC), New Haven CT in collaboration with the Cornell Scott Hill Health Center with funding from SAMHSA, developed a co-located primary care center at CMHC (CMHC is a public mental health center serving a racially and ethnically diverse population of individuals with mental illness, many presenting with chronic medical conditions).

Address client level factors

- Skill training for patients/clients
- Nurse care management and coordination
- Peer health navigation

Addressing systemic barriers

- Co-location of primary care in CMHC
- Staff from one service visit another on a regular basis
- Appointing care coordinators to liaise between services

What are the Barriers and Facilitators to Healthcare?

Our PCORI research process was participatory – meaning co-developed and produced by people in recovery and patient partners. For this portion of the project, they wanted to know:

1. What are the barriers and facilitators to healthcare for people served by CMHC? and,
2. What are some simple ways of addressing the barriers and building on what the participants say they feel are important to facilitating their access?

Method

Participants were recruited from a primary care clinic (the “Wellness Center”) co-located in a community mental health center in an urban mid-sized northeastern city. Any patient of the Wellness Center was eligible.

Barriers and Facilitators Scale was originally developed to assess barriers and facilitators to receiving healthcare for African American MSM (Bradford, 2009; Bradford, Coleman, & Cunningham 2007).

- Several items from original measure were reworded by our research partners (people in recovery that were co-researchers for the study) to ask about accessing healthcare in general.
- Participants rate 0–2 the extent to which 45 barriers interfered with their ability to receive healthcare services and 33 facilitators that helped them access and receive healthcare services.
- For barriers, the scale is 2 = a major barrier, 1 = somewhat of a barrier, 0 = not a barrier.
- For facilitators, the scale is 2 = helps a lot, 1 = somewhat helps, and 0 = does not help.

Sample characteristics

204 participants
62% Male, 37.5% Female, 0.5% Transgender
Average age: 45.3 (range is 20 to 70)
47% African American, 36% White, 6% Other, 6% Native American
32% Latino/Hispanic
67% never married/single, 49% living with another person
Highest education level achieved (years): 11.6 (SD=2.8)
Age at first hospitalization (M=23.8, SD=11.3)
Total lifetime number of hospitalizations (M=9.25, SD=15.5)
Total hospitalizations past year (M=0.6, SD=1.8)

Top 10 Barriers to "receiving healthcare services"

	Percent Barrier
1. You don't have a reliable source of transportation.	37.7%
2. You have problems remembering the appointments.	34.2%
3. You don't have stable housing.	24.1%
4. You can't afford to pay for medical care.	23.6%
5. You feel too depressed to go to the doctor.	22.1%
6. You are afraid you will have to make lifestyle changes.	20.6%
7. You have to wait too long to get an appointment.	17.3%
8. You are afraid of what your healthcare provider will tell you.	17.1%
9. You don't like to be reminded you have a certain illness.	16.8%
10/11. You have to wait too long at the doctor's office.	16.6%
10/11. The medical appointment days and times are not convenient for you.	16.6%

%= responses of "somewhat of a barrier" + "major barrier"

Top 10 Facilitators to “receiving healthcare services”

	Percent Facilitator
1. You are currently receiving mental health treatment or services.	98.4%
2/3. You like your health care provider.	98.0%
2/3. You feel you can talk to your health care provider about your needs.	98.0%
4/5. You feel your health care provider cares about you as a person.	97.5%
4/5. You understand your health care provider’s instructions.	97.5%
6. You look forward to taking charge of your health.	97.0%
7. You are treated well by the staff in your doctor’s office.	97.0%
8. You feel your health care provider listens to you.	97.0%
9. The days and times you can get appointments are convenient to you.	95.4%
10. You have a system for remembering appointments.	94.9%

%= responses of “somewhat of a facilitator” + ”major facilitator”

Discussion – Individual Differences

Several barriers and facilitators are robust across these individual differences.

- transportation being a barrier to seeking healthcare is a barrier regardless of gender, race, ethnicity, education, employment, etc.
- feeling like you can talk to your healthcare provider about your needs

Discussion - Barriers

Basic structural issues as a result of poverty are extremely important (transportation, housing, payment)

Difficulty with public healthcare that often involves long wait-times for appointments, at the doctor's office, and hours that might not be convenient

Complicated emotional experience about seeking healthcare

- especially as relates to earlier trauma experience
- including feeling too depressed to go to the doctor, being afraid of lifestyle changes, and being afraid of what the healthcare provider will tell you.

People also don't like to being reminded that they are ill.

Discussion - Facilitators

Not just removing the barriers to receiving healthcare services

- interpersonal aspects such as liking your provider, being able to talk with your provider, feeling your provider cares about you and listens to you.

Structural supports such as also

- being in mental health services,
- having systems for remembering appointments
- having appointment times that are convenient can also facilitate seeking healthcare.

Sense of agency--looking forward to taking charge of your health and feeling capable of following healthcare provider instructions.

Administrative processes and allocation of resources that enhanced the support of patient-centered care:

Accepting self-referrals instead of requiring referral by a mental health clinician.

Accommodating “walk-in” visits, for individuals who present without an appointment, whether or not it’s an “urgent" medical issue.

Expanding the hours of on-site phlebotomy services in order to meet the needs of individuals who work or have other commitments during the day.

Administrative processes (cont'd)

- Added resources for a dedicated medical receptionist to increase the ease of individuals to make or change appointments, and to provide a consistent welcoming presence at the front door and waiting area for the Wellness Center.
- Training primary care staff on Trauma Informed Care, Person Centered Care and Planning, and mental health issues and diagnoses, in order to increase their level of knowledge and sensitivity to the individuals served in the Wellness Center.

Person-centered Health Care… what Healthcare providers said post-training in this area:

1) Every person is unique thus care plans need to be patient specific.
2) Use patient's own strengths to help guide care plan.
3) Wellness is not just medical health but also spiritual and emotional health and we should incorporate this in care plans.
4) Care plans should include patient's goals not just provider's goals for patient

Collaboration of mental health and primary health staff:

1) Communication is key where flow of information should be appropriate and timely;
2) At a minimum, monthly meetings between clinicians and psychiatrist and staff of wellness clinic around patient care of our most high risk medical patients;
3) It takes a team to get the work done: Front desk, patient navigator, primary care provider, medical assistant, and nurses all play a significant role in providing services and helping patients reach their health goals; and,
4) All staff must have continued training on mental and behavioral health issues from a patient centered and recovery-oriented perspective.

Conclusions

- Talk to the people you serve, develop active advisory groups, co-develop strategies together.
- Facilitators of healthcare are essentially key elements of patient centered care.
- People want to be treated with dignity and respect.
- Understanding the barriers and facilitators to healthcare is one step in that direction.
- Training in the area of patient centered care is essential for staff learning to practice these fundamental skills of providing care.

Thank you from Project WE and CMHC

CIHS Tools and Resources

Importance of integrated care for persons with mental health and substance use disorders:

- http://www.integration.samhsa.gov/about-us/CIHS_Integration_Infographic_11x8.5_printable.pdf

Tools for patient activation:

- www.integration.samhsa.gov/resource/motivational-interviewing

- The **Patient Activation Measure**™ (PAM™) survey assesses the knowledge, skills, and confidence integral to managing one's own health and healthcare.

CIHS Tools and Resources

Visit www.integration.samhsa.gov or e-mail integration@thenationalcouncil.org

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